Guidance on reviewing patient health records under the NGPA Scheme

The National General Practice Accreditation (NGPA) Scheme supports consistency in assessment processes against the Royal Australian College of General Practitioners (RACGP) *Standards for general practices*. This fact sheet provides guidance to accrediting agencies and assessors on the minimum requirements for reviewing patient health records for assessment purposes.

Indicator QI2.1 B of the RACGP *Standards for general practices* (5th edition) (the Standards) describes requirements for active patient health records.

QI2.1 B Each active patient health record has the patient's current health summary that includes, where relevant:

- adverse drug reactions
- current medicines list
- current health problems
- past health history
- immunisations
- family history
- health risk factors (e.g. smoking, nutrition, alcohol, physical activity)
- social history, including cultural background.

This fact sheet describes the minimum requirements that must be adhered to when assessing Indicator QI2.1B by describing the:

1. number of health records sampled
2. choice of health records sampled
3. recency of health records sampled
4. documentation and other considerations during assessment.

Worked examples are also included to support consistency in application of this guidance.

1. Minimum number of health records sampled

The minimum number of health records sampled is calculated by the number of General Practitioners (GPs), rather than on a full-time equivalent (FTE) basis. This method supports greater consistency across assessments and reduces variability arising from differing FTE calculations.

The minimum patient health record sampling requirements are outlined in **Table 1**. The number of records assessed may exceed the minimum where the assessor team believes further review is warranted, including where:

- a large number of GPs are in a practice
- previous assessment reports indicate certain areas of concern related to the patient health record
- the assessor team discovers issues that warrant expanding the sampling from the minimum.

Table 1 Minimum patient health record sampling requirements

Number of GPs	Minimum number of records per assessment	Requirements for sampling across GPs
1	20 records	Not applicable
2 - 10	30 records	All GPs sampled. Records distributed as evenly as possible across all GPs, for example: • 15 records each for 2 GPs • 5 records each for 6 GPs.
11 or more	30 records	10 GPs sampled. At least 5 of the sampled GPs must be those seeing the highest number of patients for that general practice. The remaining 5 sampled GPs may be chosen by the assessor at random.

Patient health records must be sampled across all GPs who maintain patient health records, regardless of whether the GP works full time, part time, casually or as an independent contractor.

To meet Indicator QI2.1B, at least 75% of the active patient health records selected for assessment must contain a current health summary. The required number of records is rounded up to the nearest whole number. In cases where additional patient health records are sampled, the 75% applies to all sampled patient health records.

Worked example: Rating Indicator QI2.1B

The assessor team samples 30 patient records. Only 22 records contain a current health summary. The percentage of active patient health records that contained a current health summary is 73% and therefore the indicator is rated **Not Met**.

2. Choice of health records sampled

The assessors must aim to reflect a diverse range of records when determining their sample. This should include a variety of:

- clinical presentations
- age groups
- cultural backgrounds.

Assessors may use previous assessment reports to identify additional factors that support a diverse range of records when selecting the sample health records.

Sampling must be conducted without influence from the general practice being assessed.

Worked example: Choosing diverse health records

The assessor is assessing a solo GP. Upon reviewing half of the patient health records, the assessor recognises that, even though the age groups are varied, the clinical presentations do not represent the range of services offered. The assessor quickly scans the remaining sample to ensure a range of clinical presentations is present and updates the sample where appropriate.

3. Recency of health records sampled

Patient health records must be selected from consultations conducted **within the previous three months**. If the sampled GP did not practise during this period, the timeframe may be extended to the most recent period in which the GP did practise.

Worked example: Extending the sampling period

The assessor team are assessing a general practice with two GPs in July, however only one GP has been practising recently. The assessor team document the following sampling method.

- GP 1 sampled 15 records, all records between May-July.
- GP 2 sampled 15 records, all records between March-May due to leave of absence in practice.

4. Documentation and considerations during assessment

Assessors must ensure appropriate documentation of their assessment. Clear documentation within the assessment report should include the:

- application of the sampling methodology described in this fact sheet is applied and documented, including the number of patient health records reviewed per GP and the date range used for sampling
- findings of the patient health record review
- decisions that are traceable to the evidence reviewed.

To support consistency across accrediting agencies and assessors, assessors may use a standardised internal assessment tool or template when reviewing patient health records for Indicator QI2.1B that aligns with this guidance.

Health summary content versus consultation notes

Indicator QI2.1B relates specifically to the presence and currency of a patient's health summary, not to the completeness of individual consultation notes.

The health summary should contain key current information as specified in the Standards.

Consultation notes may provide context but should not be used to compensate for missing or outdated information that is expected to appear in the patient's health summary.

Assessors should clearly distinguish between these two record components when reviewing evidence, to ensure consistent interpretation of the indicator.

Identifying, following up and closing out issues

Where gaps are identified through patient health record sampling, assessors may consider whether the general practice has processes to review and improve patient health summaries over time.

This may include reviewing evidence of audit or review findings, quality improvement activities, actions taken to update health summaries and staff education or system changes.

Assessment should focus on whether the general practice has clearly defined and reasonable follow-up processes, rather than expecting immediate rectification of every issue identified during sampling.

Assessment of other indicators using patient health records

Other indicators within the Standards may involve a review of patient health records, for example:

- Informed patient decisions (C1.3A, C1.3B),
- Respectful and culturally appropriate care (C2.1C)
- Presence of a third party during consultation (C2.2A)
- Health promotion and preventative care (C4.1A).

The evidence sought for these indicators may not be easily identified through random sampling. Assessors may seek the assistance of the general practice to identify relevant patient health records to support the review.

Further verification through interviews with staff relevant to each indicator helps ensure a robust assessment process. Assessors may select interviewees independently and should not be restricted to staff nominated by the general practice.

For more information

Please visit: safetyandquality.gov.au/ngpa

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